MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Richard Taylor, D.O. P O Box 3160 Palestine, TX 75802	MDR Tracking No.: M4-04-0439-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Company 9901 Brodie Lane Ste 160 PMB 225 Austin, Texas 78748-5612 Box #15	Date of Injury: Employer's Name: Tetra Technologies, Inc. Insurance Carrier's No.: 645C175273

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
1/02/03	1/02/03	20610	$40.00	$20.00
1/02/03	1/02/03	20610	$40.00	$20.00
1/02/03	1/02/03	20610	$40.00	$20.00
1/02/03	1/02/03	20610	$40.00	$20.00

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor's position statement states in part, "…the procedure performed was sacroiliac injections to the right S1, S2, and S3 as well as the left S1, S2 and S3. The insurance carrier reimbursed for two injections and cited the fee guideline surgery ground rule I.E.4.D. …The procedure report clearly indicates six different injection sites. …Per the descriptor of CPT code 20610 this is not a per level code therefore the code may be billed bilaterally if performed…"

PART IV: RESPONDENT'S POSITION SUMMARY

The Carrier signed for the initial dispute on 9/10/93 and the additional documentation from the Requestor on 10/10/03. The Carrier did not respond.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Requestor billed for 6 separate sacroiliac injections to the right S1, S2, and S3 and to the left S1, S2 and S3. The Carrier reimbursed for 2 injections and denied additional reimbursement as "F – Fee Guideline MAR Reduction".

CPT code 20610 is not a per level code according to the CPT code descriptor. The Medical Fee Guideline, Surgery Ground Rule (I.)(E)(4)(a) states, Surgical injections delineated as per injection by CPT descriptor and nomenclature warrant additional reimbursement per injection subject to the multiple procedure rule within the same area." Reimbursement is recommended in the amount of $80.00 per the 1996 MFG, Surgery GR(I.)(D)(1)(b)(ii) ($40.00 x 50% = $20.00 x 4 DOS).

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$80.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	February 2, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____